Arizona Medication-Assisted Treatment Work Group

September 8, 2016
3:00 PM – 5:00 PM
Governor's Executive Tower
Suite – 230
1700 West Washington Street
Phoenix, Arizona 85007

A general meeting of the Access to Treatment Work Group was convened on September 8, 2016 at 1700 Washington Street, Suite 230 Phoenix Arizona, 85007, notice having been duly given.

Members Present (8)
Dr. Sara Salek, AHCCCS
Debbie Moak, Governor's Office of Youth, Faith and Family
Dr. Rick Sloan, Compassionate Care Center
Peggy Chase, Terros Health
Dr. Len Ditmanson, COPE
Dr. Gagan Singh, Banner Health
Haley Coles, Community Member
Doray Elkins, Community Member

Staff/Guests Present (3)	Members Absent (2)
Sharon Flanagan-Hyde, Flanagan-Hyde Associates	**Michael White,** Community Medical Services
Mohamed Arif, AHCCCS	**Reuben Howard** , Pascua Yaqui Tribe
Tania Lang, Cenpatico	

A. Call to Order
Debbie Moak called the meeting to order at 3:00 pm

B. Welcome, Introductions and Group Norms
Sharon Flannigan Hyde provided the group introduction and reviewed the group norms.

C. Approval of the Meeting Minutes
Dr. Len Ditmanson motioned to have the minutes approved with one change and **Dr. Michael Sucher** second the motion. The minutes were accepted with a single modification.
modification.

Peggy Chase-on page 8 of 9 just prior to letter "I" there are two comments:

- One of them shows L**en** "transitioning general mental health substance abuse portfolio to AHCCCS plans."
- And Dr. Salek clarified that "the transition of GMSA is for the duals meaning members with Medicare and Medicaid"
- **Peggy** - I would like this to be clearer so that somebody doesn't think, out of context, that all of the GMSA services are moving over from the RBHAs to the AHCCCS plans. It is just the dual eligibles that are transitioning.
- Q: **Sharon** Do want to say "**Len** - transforming GMSA portfolio for dual eligibles"?
    - A: **Peggy** -if **Len]** is willing for that change to me made, then yes.
    - A: **Len**- Yes I am okay with that clarification.

Dr. Sara Salek- [on page 8 of 9 first bullet at the top]-subsequently I followed up on the access to Methadone in Mohave County. The [AHCCCS] Contractor did clarify that there is a methadone clinic in Mohave County—Kingman.

D. <u>Discussion: Presentations-What Stood Out?</u>

No comments

F. <u>Review, Discussion, and Revision of Report Draft 1</u>

Page 25:
Sharon-find your name, make sure that is spelled correctly, title/position, organization etc.
Sara- one minor change- add word so it reads, "Task Force co-chair"

Page 26:
Sharon-Check for list of workgroup(s) that you have been involved with, make sure that we captured your name

Haley Coles-I'm incorrectly listed in the NAS workgroup, and not listed in the MAT workgroup

Sharon-we are going to look at the MAT section that starts on page 14. **Gagan** sent his comments in writing, and you have a photocopy of those changes in your packet

Page 14: Medication Assisted Treatment

- **Dr.Rick Sloan**- whenever you take Suboxone, you put it underneath your tongue and the subxone is absorbed in your body.

- Sharon-**Dr. Gagan Singh** your comment on page 26, are you suggesting an addition there or did you just want to bring this up for discussion?
- A: **Gagan**- I really wanted change that because a case report is like I saw a patient that happened to be on buprenorphine during pregnancy. Since then, there have been studies that compared performance of buprenorphine vs. methadone during pregnancy. There is a lot more literature now that says it's okay to use in pregnancy.

- My thought was that we should say something to the effect "there have been several studies reviewing the safety of buprenorphine during pregnancy. The FDA, however, classifies buprenorphine products as category C medication indicating that the risk of adverse effects have not been ruled out. If used in pregnancy it should be used by itself rather than in combination with Naloxone." Yes, this was **Gagan's** comment
- Comment-**Sara-**I agree with **Gagan.**
- Comment- **Dr. Michael Sucher-** I agree with the comments made by **Gagan.**

Page 15:

- **Sharon-Gagan,** had made a change that "the Methadone treatment should ideally last for a minimum of 12 months"…we are adding the word "ideally"

Page 16:

- **Haley-** end of the paragraph I want to add a little more about that bill—Line 6- add it protects prescribers from certain liabilities to encourage them to write prescription; it also protects individuals that administer naloxone.
- Q: **Sharon**- H**aley** could you please write the language for that and email it to me?
- A: **Haley**- Yes

- **Haley**- line 12- change to "a doctor or pharmacist can show patients, their family members, or their caregivers how to administer naloxone, administration of the medication whether intranasal or intramuscular every 2-3 minutes is recommended during a suspected opioid overdose. Patients who have naloxone should use the item available at all times in case of an emergency. Medication should be replaced when the expiration date passes. Naloxone is not effective in treating overdose benzodiazepines …or alcohol or stimulant overdoses involving cocaine or amphetamine."

- **Sharon- Gagan**, on Line 30- suggested a change so that it reads "however, MAT should be seriously considered as an effective treatment option and should always be viewed as part of a comprehensive treatment plan that includes counseling participation and social support."

- **Haley**-line 26-replace "substance abuser" with "person seeking treatment for substance use disorder"

- S**ara** - differentiate that the AHCCCS P&T committee is only for the Medicaid system it doesn't govern all insurance or coverage. As we transition to that section, we may want to look at Medicaid specific, so pull out anything Medicaid specific that we are trying to highlight.
- Q: **Sharon**-when you say "pull it out" do you want to make it clear that it is only for Medicaid?
- A: **Sara**- Yes

Page 17:

Q: **Peggy** - We talked about the number of physicians providing MAT is not sufficient for the needs today. We also have had conversations about whether or not rules will change so that more

than psychiatrists will be able to prescribe buprenorphine. Do we know any more about that? Is that something that we want to address in here—should that change happen at the federal level—then we would want to put in [page 17] methods to train and equip physicians who are appropriate do that..

- Comment: **Gagan**-I kind of saw some mention of NPs being able to prescribe…I'm not sure where…
- Comment: **Michael**-the Comprehensive Addiction Act that goes into effect in January allows for NPs and PAs with certain training to be able to treat opioid dependence with buprenorphine products. Also, there is a rule change recently allowing certain physicians to get a waiver increase from 100 patients up to 275. I'm not exactly sure what the necessary training parameters are for NPs or PAs.

Page 18:

- **Sharon**-under the recommendation section-**Gagan's** recommended adding explore the feasibility of addiction medicine fellowship in Arizona
- Comment: **Debbi**e - I'm working on that
- Comment: **Michael**-we are working on it as well
- **Gagan-** I know Debbie is working on it, but my thought was that this is an important task.
- **Reuben**-some of the recommendations are too general…increase the availability of detox services…how are we planning to do that?
- **Debbie** - the NAS workgroup, did exactly what you are proposing—they included active verbs—instead of saying "encourage" or "support" they came up with much stronger language.

- Q: **Sharon-** on page 18, line 30- "increase the availability of detox service"—how would you structure that?
- Comment: **Sara**—how do we measure that? And how do we identify the need? We hear anecdotal stories and but often times those dots are not connected. We need to understand what resources are available. And also understating where there is a gap.
- **Len**- I would say that what we need to do is create a system of needs assessment on an ongoing basis that would identify the needs of this service…is 16 enough? Is 32 enough?...so without a real-time needs assessment structure people will never know how much is enough. I would include create an ongoing system of needs assessment for the state of AZ and communities in AZ that would identify gaps in services.
- **Peggy**-We know that there is a need for residential detox, inpatient detox as well as outpatient detox—the Emergency Rooms are full of people seeking detox every day without having a full system of care to handle the capacity. I agree that we need to identify what the gap looks like. But, we know for sure that there are gaps in all three of these detox categories. And there is a significant number of people that have successfully detoxed in outpatient settings. Some of it is looking at what are the tools to help identify who should be in outpatient detox vs. inpatient or residential settings.
- **Sara**- one of the data sources that we want to consider is Department of Health Services emergency department data—I don't know the specifics related to that—but this might be a source.

- **Reuben-**we talked about outpatient detox—but there aren't enough inpatient and residential detox programs—that is a major issue for us—some of our patients are homeless—[they would not be candidates for outpatient detox].
- **Rick**-I never worked in an inpatient facility—but you are right you need to have social support to detox quicker in outpatient setting.
- **Debbie** - I believe what I hear is that this is not a one size fits all—so having multiple options that fit that individual is important…a potential recommendation—just as we have done with the prevention treatment and recovery locater on our website…we had reached out looking for the exact number of detox and treatment..i think that is something that is tangible that we can do, which is let us at least know where these beds are…and what is available.
    - Q: **Sharon**-to clarify are we talking about real-time availability or just who to call to see if there is a bed available?

- **Len**-I'm aware in the cannabis process going on right now—ADHS has information on the number of cannabis user cards in almost every geographic area of the state…and are awarding these licenses based on 5 mile availability…if we can have something to that degree in opioid treatment…
- **Reuben**-may change the word "increase" to the word "determine the availability"
- **Pegg**y- I would recommend that we leave the word "increase" in there because we know we need to increase capacity. Maybe underneath this create some sub-categories such as conducting needs assessment to determine gaps; and to have another sub-category enhancing the locator on the website..
    - Comment: **Debbie** -I agree with that idea.
    - **Reuben**-I would like to make a recommendation especially for the IV users—screening for communicable diseases as a requirement for treatment.

- **Sara**- If you look at the MAT guidelines that SAMHSA put out—screening for communicable diseases are such as HIV is in its guidelines.
- **Len**- It's interesting the only two that are required as part of the process, that is remnant of 1960 is [missing] and intra-dermal skin test. Those are the only two that are required. The others are recommended. And to Reuben's point these tests are often not available due to costs.
- Q: **Sara**-are they not available due to insurance denials? Because, for example, in Medicaid those are covered services. For me this is a standard of care in 2016 that an individual that has a history of IV drug use be screened for HCV, HIV, etc.—obviously with patient consent.
    - A: **Len**- because of the siloing of OPT and medical side of AHCCCS…these services may or may not be covered
    - Response: **Sara**- I will fully look at the behavioral health services guide to see testing for HIV, etc. But if this is an issue, it is easy to address in regards to adding so there is clarity. What drives reimbursement in our system is the principle of primary diagnosis—in general if it is medical it will go to our acute health plan and if it's behavioral it's going to go to the RBHAs.
- **Sharon**-The recommendation then would be to require screenings for communicable disease…Do you want to list specific which ones?

- **Reuben**-Hep C, HIV, AIDS, STDs,
- **Len**- Zika
- **Haley**- I don't like the idea of requiring OTPs to screen. But, I support OTPs to have the resources to screen those who want it.
  - **Sara**- I agree
- **Haley**- My experience with screening Hep C in methadone clinics is that 33% of people we screen were positive for Hep C. I think if we require it, some folks will opt out of treatment because they don't want to be screened.
- **Reuben**-But, at the same time these individuals have families, partners, kids…I think you should require it…but if they choose not to…you can't force them to
- **Haley**-But it shouldn't be a prerequisite for getting treatment…OTPs should routinely offer these tests to individuals seeking treatment. But, it shouldn't be a requirement for treatment.

- **Haley**-Does AHCCCS reimburse for rapid screening?
  - **Sara** -I would need a specific code to tell you if it's covered or not.

Reuben-the last recommendation-"naloxone" and "non-opiate opiate blocker Vivitrol"—what does that mean?

- **Sara-**I think it means to promote greater use of naloxone to prevent deaths due to overdose. In regards to Vivitrol that is one MAT—it would make sense to include this under the first bullet—Vivitrol is one component of MAT. So, increasing prescriber awareness of all MAT including Suboxone and Vivitrol.
- **Doray**-Vivitrol is not getting the type of awareness it needs in our state.
- **Len-** from my experience, I was in the treatment community for 14 years before Vivitrol was made available in the formulary to current RBHAs…but for 13 of those years it was categorically unavailable. In my practice alone I have gone to almost 20 people just since it was made formulary. But, I considered it fully in the spectrum of all of the tools in the toolbox. It may have benefits in the long-term…but I agree with **Sara**…we just don't have the long-term studies. Are they really out of the woods a year after treatment? Or are they still susceptible to relapsing back in to opioid addiction? I don't think that data is available yet. So I wouldn't promote necessarily as a superior end point.
- **Debbie** -I like **Sara's** suggestion to put Vivitrol with the other MATs—I would like for us to somehow do a better job educating doctors and the community at large that there is an antagonist option available.
- **Haley-** I would like to have stronger language around Naloxone, other than promoting greater use of it. Specifically, it would be nice to say promote greater use of Naloxone, especially in populations that are susceptible to fatal overdose such as people getting out prison, veterans, individuals coming out of the emergency rooms. Perhaps specifying that--because that is an indicator for people that work in the prisons or jails and other folks that work with vulnerable populations that they should be focusing on Naloxone distribution. I would also like to include something about funding for Naloxone kits for folks who are not able to access it from a doctor or pharmacist.
- Q: **Sharon**-when you are saying "funding" what source of funding are you suggesting?
  - **Haley**-potentially state funding?

- **Gagan-**to the first point that make sense and should be part of the MAT. The second piece, I agree with what was said. But, I wonder if this belongs with the early intervention and prevention recommendation rather than the MAT workgroup recommendation.
- **Debbie** -I will tell you from my experience from having sat through all of the workgroups they are really on a different track…I don't feel that the direction that they have taken with the workgroup that is a really good fit.
- **Gagan**-We definitely need harm reduction strategies as Haley was talking about. This is a crucial piece of the work that needs to presented. If we are the only ones that can do that then it makes sense.
- **Sharon**-does the work group have consensus around addressing funding for Naloxone?
    - **Haley**-people on AHCCCS currently have Naloxone paid for…but it requires that they go to the doctor and then go to a pharmacy…a lot people are not going to make it to the doctor and if they do…they will not make it to the pharmacy. And for people who have private insurance…they are looking at a copay around $150…and there are folks that don't have insurance at all…I would argue that the people who are the most vulnerable are those who are not going to use traditional means to obtain Naloxone.
    - **Len**-What is the denominator? How many Naloxone kits should we have out there? How big is that at risk-high-risk population? Another needs assessment…in Pima County they have a robust needle exchange program using county funds…exchanging clean needles. Is there some way that the State or local county government could identify to screen populations who are deemed to be high risk and find appropriate funds to prevent death? The feedback that I have heard from legislatures is when you start talking about numbers—is it 100,000 Naloxone kits? 50,000 kits? Actually within that context the clean needle exchange folks are aware of the highest risk populations.
    - **Debbie** - I felt a bit uncomfortable when the word "funding" came up…I feel that we will diminish our opportunity when we start adding the word funding in front of it…sadly, this year AZ was not in the position to write for a SAMHSA grant that did have funding for Naloxone. However, I want to congratulate AHCCCS for receiving a SAMHSA grant—just a week or two ago—for medically assisted treatment—$1,000,000 a year for the next three years.
    - **Doray**-we should do some work to see what the at-risk populations are…and where the trend is going…I also thought of a possibility that the companies that make it can donate some kits.

Gagan—how about some recommendation exploring the feasibility of increasing harm reduction strategies…needle exchange and availability of naloxone kits.

- **Debbie** -except that we had a previous conversation around the word "needle exchange"
- **Haley**-I don't recall syringe injection programs in this workgroup…but, I do remember talking about syringe injection programs in the access to treatment workgroup
- **Sara-**I know some of the historic concerns related to it
- **Sharon-** there was a consensus in the other workgroup not to include needle exchange because of concerns about diluting the impact of the recommendations that have a greater

chance of being implemented by things that would trigger some people to not take any of the recommendations seriously.

- **Len**-It's also still illegal at the federal level
- **Haley**-I remember in that workgroup that there was a lot of support…I remember that there was concern…just like what you have mentioned, Sharon. But, I remember that most of the people in that workgroup showed support that we look at state level recommendation for syringe injection programs….there is federal funding available for syringe injection programs now. So this might be better for the access to care workgroup as it aligns with some of the recommendations from that group…
- **Debbie**-we are operating in a political environment whether we like it or not…I wish to have our time spent on moving forward items that will be seriously considered and implemented. And I personally don't want to put this on this agenda.
- **Sharon**-for others in this workgroup…is there anyone else who wants to advocate for continuing the conversation about needle exchange?
    - **Debbie**-I will be the first to say that everyone in the workgroup…you have an opinion and vote that matters…just because I feel this way doesn't make it so. But, this is the time to weigh in…
    - **Doray**-needle exchange programs have been successful…the numbers have been astonishing. However, it may not be a conversation for today…I'm glad that it is a conversation because I see a great success with it
    - **Sharon**-as the facilitator, I am not perceiving consensus around the table with respect to including needle exchange in this report. What we have seen with similar groups is that a Task Force like this provides an opportunity for individuals to get to know each other…and connect outside of the work of the Task Force to move forward on issues that may not have reached the level of consensus.
    - **Sharon-Haley** and D**oray** are you okay with a consensus to not include this in the report?
        - Doray-Yes
        - Haley-Yes

Gagan- Page 18-Line 41 and 42- the next section re target strategies—recommending to call out rural and Native American communities

- **Len**-Agree

Len-we need to promote all three MAT settings—need to highlight that in the recommendations

- **Sara**-I am working on that

Peggy-we have had a few conversations around alternative pain management options…I didn't see that in the recommendations

Len- Page 5 line 17-the recommendation says require and expand provider education regarding opioid us for pain management.

Peggy-I read that as well…educating around opioid use versus looking at what are the alternative methods of use…it really didn't go into adopting and teaching alternatives

J. <u>Call to the Public</u>

No members of the public spoke.

K. <u>Adjourn</u>

Rick motioned to adjourn, 2nd Reuben. The meeting was adjourned at 4:52 p.m.

September 8, 2016
Medication-Assisted Treatment Work Group
Respectfully Submitted By:
Mohamed Arif, AHCCCS